SECTION II - DENTAL

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200.000 DENTAL GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Dentists

201.100 Individual Providers of Dental Services in Arkansas and Bordering States 11-1-09

Dental services providers in Arkansas and bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

Dental providers must be licensed by the State Board of Dental Examiners to practice in their state. A copy of the current dental license must accompany the provider application and Medicaid contract.

201.110 Individual Providers of Oral and Maxillofacial Surgeon Services in Arkansas and Bordering States 11-1-09

Oral and maxillofacial surgery services providers in Arkansas and bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid program as an oral and maxillofacial surgeon specialist:

A. A copy of certification letter and license from the Arkansas State Board of Dental Examiners or other licensing state verifying completion of all requirements for a specialty license in oral and maxillofacial surgery must be provided.

or

B. A current copy of annual renewal receipt from the Arkansas State Board of Dental Examiners or other licensing state certification must be provided. Subsequent renewal verification must be provided when issued.

C. A current copy of the DEA certificate issued by the Drug Enforcement Agency (DEA) must accompany the provider application (DMS-652) and the Medicaid contract (DMS-653). Subsequent certification by the DEA must be provided when issued.

201.200 Individual Providers of Dental or Oral and Maxillofacial Surgeon Services in Non-Bordering States 10-13-03

Individual providers of dental or oral and maxillofacial surgery services in non-bordering states may be enrolled only as limited services providers.

201.210 Individual Limited Services Providers in Non-Bordering States 3-1-11

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file.

To enroll, a non-bordering state provider must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit Contact information.**

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Group Providers of Dental or Oral and Maxillofacial Surgeon Services in Arkansas and Bordering States 11-1-09

Group providers of dental or oral and maxillofacial surgery services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a dentist is a member of a group, each individual dentist and the group must both enroll according to the following criteria:

A. Each individual dentist within the group must enroll following the criteria established in Sections 201.100 and 201.110.

B. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled licensed dentist within the group.

201.400 Group Providers of Dental or Oral and Maxillofacial Surgeon Services in Non-Bordering States 10-13-03

Group providers of dental services in non-bordering states may be enrolled only as limited services providers.

201.410 Group Limited Services Providers in Non-Bordering States 3-1-11

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file

To enroll, a non-bordering state provider must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit Contact information.**

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.500 Dentist Role in the Child Health Services (EPSDT) Program 1-15-11

The Child Health Services (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive healthcare to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive healthcare, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

A. Early and periodic screening and diagnosis and treatment (EPSDT) is a healthcare program designed for (1) health evaluations as soon after birth as possible, (2) repeated at regular recommended times, (3) to detect physical or developmental health problems and (4) healthcare, treatment and other measures to correct or improve any defects and chronic conditions discovered.

1. Screening

   The Arkansas Medicaid Program recommends for **all** eligible EPSDT beneficiaries under 21 years of age, regularly scheduled examinations and evaluations of their general physical and mental health, growth, development and nutritional status.

   These screenings must include, but are not limited to:

   a. Comprehensive health and developmental history.
   b. Comprehensive unclothed physical examination.
   c. Appropriate vision testing.
   d. Appropriate hearing testing.
   e. Appropriate laboratory tests.
   f. Dental screening services furnished by direct referral to a dentist for children within 6 months after the first eruption of the first primary tooth, but no later than 12 months (per the American Academy of Pediatrics).

   Screening services must be provided in accordance with reasonable standards of medical and dental practice; as soon as possible in a child's life; and at intervals established for screening by medical, dental, visual and other healthcare experts.

   An age appropriate screening may be performed when a child is being evaluated or treated for an acute or chronic condition and billed as an EPSDT screening. See the EPSDT manual for information regarding EPSDT screenings.

2. Diagnosis

   Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health, history, physical, developmental and psychological examination, laboratory tests and X-rays.

3. Treatment

   Treatment means physician, hearing, visual services or dental services and any other type of medical care and services recognized under state law to prevent or correct disease and abnormalities detected by screening or by diagnostic procedures.

   Physicians and other health professionals who perform a Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment. If immunization is recommended at the time of screening, immunization(s) **must** be provided at that time, **or a direct referral given**.

If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations.

B. Child Health Services (EPSDT) providers are encouraged to refer to the EPSDT provider manual for additional information. Information can be obtained by going to the Arkansas Medicaid website at **https://medicaid.mmis.arkansas.gov/** and by checking on provider information.

Dentists interested in becoming a Child Health Services (EPSDT) provider may contact the central Child Health Services Office. **View or print Child Health Services contact information.**

201.600 Dentist Role in the Pharmacy Program 3-14-15

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

PRESCRIPTION DRUG INFORMATION

If you have prescription drug prior authorization concerns, please call the Prescription Drug PA Help Desk. **View or print Prescription Drug PA contact information.**

Prescribers may also refer to the website at **https://arkansas.magellanrx.com/provider/documents/** to obtain the latest information regarding prescription drug coverage.

201.601 Tamper Resistant Prescription Applications 2-6-17

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled;

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally-specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

202.000 Documentation Requirements 11-1-09

Dental providers must keep and properly maintain written records. Along with the required enrollment documentation, which is located in Section 141.000, the following records must be included in the provider's files.

202.100 Dental Records Dentists are Required to Keep 7-1-12

All dental providers are required to maintain patient records set forth in Section 142.300.

Documentation of provided services must be maintained in the patient record, and all entries must be signed and dated by the dental provider. Documentation must consist of, at a minimum, material that includes:

A. History and dental examination on initial visit

B. Chief complaint on each visit

C. Tests, X-rays and results

D. Diagnosis

E. Treatment, including prescriptions

F. Signature or initials of dentist after each visit

G. Copies of hospital and/or emergency room records

Specific information about the recommended maintenance of dental records can be obtained from the American Dental Association Council on Dental Practice.

202.200 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

202.300 Dental Service Standards and Professional Requirements 7-1-12

Dentists participating in the Arkansas Medicaid program must deliver professional services in accordance with the rules and regulations of the Arkansas Medicaid program and in accordance with the Arkansas Dental Practice Act and its applicable rules and regulations. Dental care must be consistent with the current guidelines and standards of care as determined by a dentist's or dental specialist's peer group.

All dental providers must be qualified by training and experience to complete appropriate treatment plans that are consistent with Medicaid and professional guidelines. Dental providers are expected to refer to the appropriate specialist if necessary.

All therapeutic agents and materials must meet the specifications of the American Dental Association (ADA); and all dental services, including record keeping, examinations, radiographs/images, and restorative, preventive and surgical treatment must be provided in accordance with the ADA guidelines. Further, all procedures performed and billed must be coded according to the Current Dental Terminology (CDT) as established by the ADA.

Please see the appropriate sections for specific treatment guidelines.

203.000 Monitoring Performance of the Dental Equipment Supplier 7-1-09

The Arkansas Medicaid Program uses a single dental laboratory selected through a competitive bid process to furnish dentures for eligible Medicaid beneficiaries age 21 and over. The Medicaid Program's Medical Assistance Unit depends on dental providers to assist in monitoring the performance of the contractor both in quality of product and timeliness of delivery. The following procedures must be followed:

A. The Medical Assistance Unit welcomes positive and negative comments regarding the dental laboratory's performance. All comments regarding the dental laboratory's performance must be made on the Vendor Performance Report. **View or print the Vendor Performance Report.** The provider will complete the Vendor Performance Report at any time a beneficiary verbally expresses dissatisfaction with his or her dentures.

B. Vendor Performance Reports should be mailed to the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

C. The Medical Assistance Unit, upon receipt of the Vendor Performance Report, will log and investigate the complaint.

D. A copy of the report is kept on file and may be a factor in awarding future contracts.

To assist the Medical Assistance Unit in investigating the report, the following guidelines are suggested when submitting a Vendor Performance Report:

A. Agency and address - enter dental provider agency name, address and phone number

B. Vendor and address - enter name and address of dental laboratory

C. Include the date the patient was examined and the date the claim and prescription were submitted

D. Indicate the date the dentures were delivered

E. Describe specific problems, e.g., poor quality (explain in detail), failure to deliver in a timely manner, unauthorized substitution, etc.

F. Give name and ID number of the Medicaid beneficiary

G. If the provider's staff has previously contacted the dental lab about a problem, note the date of contact, the name of the person who made the contact and the name of the persons contacted. Include any pertinent information related to the contact.

Copies of the Vendor Performance Report may be obtained by calling the Division of Medical Services, Medical Assistance Unit.

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-09

The Arkansas Medicaid Program covers dental services for Medicaid-eligible beneficiaries under the age of 21 years through the Child Health Services (EPSDT) Program and also has limited coverage of services for individuals age 21 and older.

212.000 Summary of Coverage 2-1-22

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the $500.00 benefit limit for adults.

Medicaid dental procedure codes are listed in **Section 262.100** for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in **Section 262.200**. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. **Section 262.200** also lists the procedure codes that are benefit limited.

212.100 Medical and Surgical Services Provided by a Dentist 10-13-03

Beneficiaries age 21 and over are allowed twelve visits per state fiscal year for medical services provided by dentists, physician's services, rural health clinic core services, medical services furnished by optometrists, certified nurse midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Medical services that are provided by a dentist for individuals under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Surgical services are covered for beneficiaries of all ages if the services are medically necessary.

212.200 Oral and Maxillofacial Services 10-13-03

In order to provide oral and maxillofacial surgery services to an Arkansas Medicaid beneficiary, the dentist must meet the qualifications outlined in Sections 201.110 and 201.300 and enroll as an oral and maxillofacial surgeon. Oral and maxillofacial surgeon services that are medical in nature (e.g., fracture, cyst removal) require a referral by the primary care physician (PCP).

Nitrous oxide/analgesia N_20 is covered when used with a surgical procedure or a procedure other than examination, prophylaxis, fluoride, sealants and X-rays.

212.300 Dental Services Provided by a Mobile Dental Facility 1-1-11

Dental Services Provided by a Mobile Dental Facility

A mobile dental facility is any self-contained, intact facility in which dentistry and dental hygiene are practiced and that may be towed, moved or transported from one location to another.

A mobile dental facility must enroll by completing the Arkansas Medicaid provider application and contract. Mobile dental facilities must meet all criteria of a dental group and submit the same enrollment documentation stated in Section 141.000 and Section 201.000. Additionally, mobile dental facilities must maintain and submit with their Arkansas Medicaid provider application and contract a copy of their mobile facility permit issued by the Arkansas State Board of Dental Examiners. Each individual dentist practicing within the mobile dental facility must also be an

Arkansas Medicaid provider and will need to complete Section IV "Group Affiliation" of the Arkansas Medicaid provider application.

NOTE: Mobile providers of Dental or Oral and Maxillofacial Surgeon Services in bordering and non-bordering states cannot enroll.

Billing Procedures

All mobile dental facilities are "pay to" providers only. This service must be performed and billed by a licensed/enrolled dentist with the mobile facility.

NOTE: For providers filing on the paper ADA claim form, mark section 38, select the appropriate POS and complete section 56 (service address).

213.000 Tooth Numbering 4-1-05

Arkansas Medicaid uses an enumeration system to identify regular and supernumerary teeth in children and adults.

A. The system was devised by the American Dental Association in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

B. It includes a numbering system to identify permanent and permanent supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth.

1. Valid values for regular permanent teeth include the numbers 1 through 32.
2. Numbers 51 through 82 indicate supernumerary permanent teeth.
3. Alpha letters A through T indicate regular deciduous teeth.
4. AS through TS indicate supernumerary deciduous teeth.

View or print a description of the tooth numbering method to be used for all Medicaid claims.

214.000 Consultations 4-1-05

A consultation includes services provided by an oral surgeon whose opinion or advice is requested by an oral surgeon or other appropriate source for the further evaluation and/or management of a specific problem. When the consulting oral surgeon assumes responsibility for the continuing care of the patient, any subsequent service provided by him or her is not a consultative service.

Consultations are limited to two per beneficiary per year in an oral surgeon's or physician's office. This yearly limit is based on the state's fiscal year, July 1 through June 30. Extensions of this benefit are available to beneficiaries under the age of 21 when the consultation is medically necessary.

These procedures must be billed on the American Dental Association (ADA) claim form by oral surgeons enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary.

214.100 Tobacco Cessation Products and Counseling Services 2-1-22

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

Counseling services and benefits are defined below:

A. Prescribers must review the Public Health Service (PHS) guideline-based checklist with the patient.

B. The prescriber must retain the counseling checklist and file in the patient records for auditing. **View or print the checklist**.

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. For beneficiaries age twenty-one (21) and over, counseling procedures will count against the $500 adult dental benefit limit. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under that minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Beneficiaries who are pregnant are allowed up to four (4) 93-day courses of treatment per calendar year.

NOTE: The course of treatment is defined as three consecutive months.

F. If the beneficiary is in need of intensive tobacco cessation services, the provider may refer the beneficiary to an intensive tobacco cessation program: **View or print the Arkansas Be Well Referral Form.**

G. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

H. Tobacco counseling for the control and prevention of oral disease must be billed when the provider counsels and refers the beneficiary to an intensive tobacco cessation program.

I. Behavior management by report must be billed when tobacco counseling for the control and prevention of oral disease has been provided to the beneficiary.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

J. Refer to **Section 262.100** and **262.200** for procedure codes and billing instructions.

215.000 Child Health Services (EPSDT) Dental Screening 2-1-22

The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Services (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) periodic dental screening exam is limited to two screening exams every six (6) months plus one (1) day for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See **Section 262.100** to view the procedure code for periodic dental screening exams.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening exam twice per SFY. Extension of benefits is available in cases of medical necessity. **View or print form ADA-J430.** See **Section 262.100** for the interperiodic dental screening exam procedure code.

NOTE: ARKids First-B beneficiaries may also receive an interperiodic dental screening exam twice per SFY. There is no extension of benefits for ARKids First-B beneficiaries.

Extension of benefits requests, in addition to a narrative and any supporting documentation, should be submitted to the Division of Medical Services Dental Care Unit – ATTN Dental Extension of Benefits. **View or print the Division of Medical Services Dental Care Unit contact information**.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

216.000 Radiographs 10-13-03

Radiographs (X-rays) should be kept to a minimum to be consistent with good diagnostic procedure. **Medicaid dental consultants examine each radiograph before a coverage determination is made; therefore, the radiographs must be of sufficient quality to be readable.** When the radiograph quality is too poor to read, the radiograph must be retaken at no additional charge to the Medicaid Program or the beneficiary.

Periapical X-rays must be taken to substantiate the need for extractions and/or restorations and endodontia. Periapical X-rays are limited to four per visit without a prior authorization.

When submitting radiographs with a request for authorization, the dentist must ensure that the films are properly mounted, marked R (right) and L (left) and stapled to the ADA claim form. To ensure proper identification, the dentist's name, the patient's name and the date taken must be on the film. Each film must be dated. Any radiographs submitted for review must be mailed to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Do not mail X-rays to the Arkansas Medicaid fiscal agent.

All X-rays are returned to the provider. All X-rays pertaining to a Medicaid beneficiary must be retained for three years and must be made available, upon request, to authorized representatives of the Division of Medical Services.

216.100 Complete Series Radiographs for Beneficiaries of All Ages 7-1-09

A complete series of intraoral radiographs is allowable for beneficiaries of all ages only once every five years. Any limits may be exceeded based on medical necessity (e.g., traumatic accident) for beneficiaries under age 21.

A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.

B. Only one complete series is covered. A complete series may be:

   1. Intraoral, including bitewings, or
   2. Panoramic, including bitewings.

C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.

D. **Prior authorization (PA) is required for panoramic radiographs of children under age six.**

E. When referrals are made, the patient's X-rays must be sent to the specialist.

F. For instructions when billing for a complete series, see Section 262.400.

216.200 Bitewing Radiographs 2-1-22

Bitewing radiographs are covered for beneficiaries of all ages. There are different limitations of coverage for beneficiaries under age 21 and for those beneficiaries age 21 and older.

The EPSDT periodic screening exam may include only two bitewings and is allowed every six (6) months plus one (1) day for beneficiaries under age 21. See **Section 262.100** for the appropriate procedure code.

Two bitewing films are allowed once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. See **Section 262.200** for appropriate procedure codes.

216.300 Intraoral Film 2-1-22

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code must be used for the first film and procedure code for each additional single film.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the beneficiary identification number and stapled to the back of the claim form, as noted in Section 216.000.

217.000 Preventive Services

217.100 Dental Prophylaxis and Fluoride Treatment 2-1-22

Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to Provider Enrollment. The course that meets the requirements outlined by the ACT can be accessed at **http://ar.train.org**. If further treatment is needed due to severe periodontal problems, the provider must request prior authorization with a brief narrative.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Topical fluoride treatment or fluoride varnish is covered every six (6) months plus one (1) day for beneficiaries under age 21.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

A. Periodic EPSDT screening exam (for beneficiaries under age 21).

B. Prophylaxis, topical fluoride and/or fluoride varnish.

C. Periapical X-rays, amalgam-composite restorations (except four or more surfaces).

D. Pulpotomies for deciduous teeth. (Pulpotomies are not a covered service for beneficiaries age 21 and over.)

E. Chrome crowns on deciduous teeth.

See Sections 262.100 and 262.200 for applicable codes.

217.200 Dental Sealants 7-1-09

Dental sealants constitute preventive treatments available for eligible beneficiaries under age 21. Coverage is once per lifetime for 1st and 2nd permanent molars only.

Dental sealants are not covered for beneficiaries age 21 and over.

218.000 Space Maintainers 2-1-22

Space maintainers are covered for beneficiaries under age 21 and require prior authorization. X-rays must be submitted with the request for prior authorization. When submitting a treatment plan or claim for space maintainers, identify the missing tooth in the tooth column on the ADA claim form and submit the X-ray to show the tooth for which the space is maintained. See **Section 262.100** for applicable procedure codes.

Space maintainers are not covered for beneficiaries age 21 and over.

218.100 Diagnostic Casts (Dental Molds) 7-1-12

Diagnostic casts (dental molds) are covered for beneficiaries of all ages; however, there are benefit limits for beneficiaries age 21 and over. **For more information regarding diagnostic casts, see Sections 226.000, 262.100 and 262.200.**

For more information regarding diagnostic casts for dentures for beneficiaries age 21 and over, see Section 223.000.

219.000 Restorations

219.100 Amalgam Restorations 2-1-22

Amalgam restorations are to be used on all teeth distal to the cuspids for beneficiaries of all ages. When submitting a claim for amalgam restorations, the tooth (teeth) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. Amalgam restorations do not require prior authorization. If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate. See Sections 262.100 and 262.200 for applicable procedure codes.

219.200 Composite Resin Restorations 2-1-22

Composite-resin restorations may be performed for anterior teeth for beneficiaries of all ages. Four or more surface composite-resin restorations require prior authorization. When submitting a claim for composite restorations, the tooth number(s) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. **If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate**. See Sections **262.100** and **262.200** for applicable procedure codes.

Only one amalgam or composite restoration per surface is allowed every 2 years.

220.000 Crowns – Single Restorations Only 2-1-22

Crowns are covered for individuals of all ages.

A. Chrome (Stainless Steel) Crowns - The Medicaid Program will cover chrome (stainless steel) crowns on deciduous posterior teeth only as an alternative to two or three surface alloys. Medicaid will cover chrome crowns on permanent posterior teeth only for loss of cuspal function. Stainless steel crowns on deciduous teeth do not require prior authorization. Prior authorization is required for crowns on all permanent teeth.

B. Anterior Crowns - Prefabricated stainless steel or prefabricated resin crowns may be approved for anterior teeth for beneficiaries under age 14. Prior authorization is required, and X-rays must be submitted to substantiate need.

C. Cast Crowns - Medicaid does not cover cast crowns for posterior teeth.

D. Porcelain-to-Metal Crowns - Porcelain-to-metal crowns may be approved only in unusual cases for anterior incisors and cuspids for beneficiaries under age 21. These cases must be submitted for prior authorization (PA) with complete treatment plans for all teeth and complete series X-rays or panoramic film with bitewings. Photographs are helpful, but are not required.

E. Post and Core in Addition to Crown - Medicaid does not cover core buildups or post and core buildups. This includes an amalgam filling with a stainless steel crown. An exception to this rule may be anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch.

Fillings are not allowed on tooth numbers with crowns within one year of the crown.

See Sections **262.100** and **262.200** for applicable procedure codes.

221.000 Endodontia 2-1-22

Pulpotomy for deciduous teeth may be performed without prior authorization for beneficiaries under age 21. **Pulpotomies are not covered for individuals age 21 and over.**

Current indications require carious exposure of the pulp. Payment for pulp caps is included in the fee for restorations and is not payable separately.

Endodontic therapy is not covered for individuals age 21 and over.

To be reimbursed, the completed endo-fill should conform to current standards, that is, complete obturation of all canals to within 1mm to 2mm of radiographic apex.

The fee for endodontic therapy does not include restoration to close a root canal access, but does include films for measurement control and post-op.

Medicaid does not cover endodontic retreatment, apexification, retrograde fillings or root amputation. **See Section 262.100** for applicable procedure codes.

222.000 Periodontal Procedures 2-1-22

Periodontal treatment is available for beneficiaries of all ages. When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and X-rays are required. Each quadrant to be treated must be indicated on separate lines when requesting prior authorization or payment. Prior authorization will require a report, a periochart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. See Sections **262.100** and **262.200** for applicable procedure codes.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs 2-1-22

A. Benefits

Full and acrylic partial dentures are covered for beneficiaries of all ages. Full dentures or acrylic partial dentures may be approved for use instead of fixed bridges.

Beneficiaries age 21 and over are allowed only one complete maxillary denture and one complete mandibular denture per lifetime.

Beneficiaries age 21 and over are allowed only one upper and one lower partial per lifetime.

Repairs of dentures and partials are covered but are benefit-limited for beneficiaries age 21 and over. See Sections **262.100** and **262.200** for applicable procedure codes.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

B. Prior Authorization Requirements

Prior authorization is required for dentures (full or partial) for beneficiaries under the age of 21.

Prior authorization is required for partial dentures for beneficiaries age 21 and over.

Prior authorization is not required for full dentures for beneficiaries age 21 and over.

For dentures that require prior authorization, a complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by partial dentures, must be submitted with prior authorization requests. See Sections **262.100** and **262.200** for further information regarding prior authorization for dentures.

Prior authorization is required for repairs of dentures and partials for eligible beneficiaries of all ages. A history and date of original insertion must be submitted with the prior authorization request. See Sections **262.100** and **262.200** for applicable procedure codes.

C. Required Process for Submitting Adult Dentures and Partials to Dental Lab

For eligible Medicaid beneficiaries age 21 and over, all dentures, whether full or partial, must be manufactured by the Medicaid-contracted dental lab. **View or print contact information for Medicaid Dental Contractor.**

When Medicaid issues a prior authorization for partial dentures for a beneficiary age 21 and over, the **Dental Lab Request Form** with the prior authorization number is returned to the dental provider's office. When the dental provider receives the prior authorization, the authorization will be for a maximum of six (6) (three upper and three lower) limited oral

evaluations/problem-focused visits along with authorization for the diagnostic casts. The dental provider must then send the Medicaid-contracted dental lab the completed **Dental Lab Request Form** with the prior authorization number and models to make the adult partial dentures. **If the dental lab does not receive the Dental Lab Request Form, the lab will make the partial dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid. View or print contact information for Medicaid Dental Contractor.**

Though prior authorization is not required for full dentures for beneficiaries age 21 and over, the dental provider must send the **Dental Lab Request Form** and models directly to the Medicaid-contracted dental lab. The **Dental Lab Request Form** must clearly indicate that the beneficiary is a Medicaid beneficiary and the dentures are being requested pursuant to the Medicaid benefit plan. **If the dental lab does not receive the request form, the lab will make the full dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** The dental provider will be reimbursed for a maximum of six (6) (three upper and three lower) limited oral evaluations/problem-focused visits and two (2) (one upper and one lower) diagnostic casts. **View or print contact information for Medicaid Dental Contractor.**

D. Patient Consent

Dental offices that render a patient edentulous must also fabricate dentures for the patient. If the patient has indicated that he or she is willing to pay out of pocket to have the dentures fabricated by the dental office and not through the contracted Medicaid Dental Lab, then the dental office must secure the patient's written consent on a form to be designed by the dental office and maintained in the patient's record. Beneficiaries who purchase dentures outside of the Medicaid dental program remain eligible for the Medicaid once-in-a-lifetime denture benefit.

224.000 Adjustments and Relines of Dentures for Beneficiaries Age 21 and Over — 7-1-09

Dentures may be relined once every three years and three adjustments of dentures are allowed per lifetime for beneficiaries age 21 and over.

225.000 Oral Surgery — 7-1-12

Arkansas Medicaid patients under 21 are eligible for extractions of symptomatic teeth that are involved with acute pain, infection, cyst, tumor or other neoplasm, a radiographically demonstrable pathology that may fail to elicit symptoms, and extractions that are necessary to complete an approved orthodontic treatment plan. Extractions of asymptomatic teeth are covered when associated with a diagnosed pathology, part of an approved orthodontic treatment plan or in the best judgment of the dentist will prevent future periodontal or orthodontic problems later in the patient's life.

Dental records must include documentation, including radiographs, to justify medical or dental necessity for all extractions. Modifications to codes for surgical extractions may occur based on diagnostic radiographs, particularly if the radiographs do not depict the degree of difficulty. In such cases, dental providers should include photographs or written narratives in the patient's dental record to justify the extraction.

225.100 Simple Extraction — 2-1-22

Simple extractions may be performed without prior approval. Simple extractions of 3rd molars do not require prior authorization.

When a simple extraction evolves into a surgical extraction, providers must write a brief explanation of the circumstances if the problem is not indicated on the X-ray. Normally, surgical

extractions imply sectioning, suturing and bone removal or any combination of these procedures. Providers must submit the claim, with the X-ray, for authorization and payment to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**. See Sections **262.100** and **262.200** for applicable procedure codes.

225.200 Surgical Extractions 2-1-22

Surgical extractions for beneficiaries of all ages require prior authorization and X-rays to substantiate need. The dental consultant may require a second opinion when reviewing treatment plans for extractions.

Surgical extractions performed on an emergency basis (See Section 234.000) for relief of pain may be reimbursed subject to the approval of a Medicaid dental consultant. In these cases, the claim with X-ray and a brief explanation should be submitted to the Division of Medical Services Dental Care Unit**. View or print the Division of Medical Services Dental Care Unit contact information**.

For beneficiaries under the age of 21, the fee for surgical extraction includes local anesthesia and routine post-operative care. See Sections **262.100** and **262.200** for applicable procedure codes. Anesthesia is not a covered service for beneficiaries 21 and over.

225.300 Traumatic Accident 2-1-22

In cases of traumatic accident and when time is of prime importance, the dental provider may perform the necessary procedure(s) immediately. The procedure code chart found in Sections **262.100** and **262.200** identifies the procedures that may be billed "By Report" and those which must be prior authorized before reimbursement may be made. The chart also indicates the procedures that require submission of X-rays. Pre- and post-operative X-rays, if requested, must be made available to the Division of Medical Services.

225.400 By Report 10-13-03

When "By Report" is indicated on the Medicaid procedure code listings, the dental provider is required to attach a concise report of the procedure to the claim form when submitting the claim for payment. X-rays and hospital records, upon request, must be made available to the Division of Medical Services.

225.500 Deep Sedation and General Anesthesia 2-1-22

Providers administering general anesthesia services must possess the appropriate permit as required by Arkansas law. Services performed in the dental office must be documented in the patient's record to include specific information on intubation, pharmacologic agents and amounts used, monitoring of vital signs and total anesthesia time. Prior authorization is required for deep sedation and general anesthesia procedures. General anesthesia and intravenous sedation will not be reimbursed for periods of time in excess of two (2) hours. Are not allowed on the same day.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

These codes are subject to post payment review; therefore, providers should be prepared to justify utilization of these procedures and the amount of time patients were kept under deep sedation and general anesthesia.

226.000 Orthodontics 8-1-15

Medically necessary orthodontic procedures are covered services, but require prior approval. **Orthodontic treatment is not available for beneficiaries age 21 and over.**

Orthodontics is only approved for the **most severe** malocclusions. Assessment of the most severe malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing/impacted teeth, overjet, overbite, openbite and crossbite.

Because a case must be severe to be accepted for orthodontic treatment, beneficiaries whose molars and bicuspids are in good occlusion seldom qualify. Crowding or spacing alone does not qualify. Arkansas Medicaid does not cover orthodontic services primarily for cosmetic purposes.

The Handicapping Labio-Lingual Deviation (HLD) Index is used to determine the eligibility for orthodontic services. The form DMS-32-0 must be completely filled out and submitted along with diagnostic records. **View or print form DMS-32-0.**

226.100 Comprehensive Orthodontic Treatment 8-1-13

The following requirements must be met to obtain comprehensive orthodontic treatment through Arkansas Medicaid. The beneficiary must:

A. Be under 21 years of age with severe malocclusions.

B. Exhibit good oral hygiene.

C. Be over 13 years of age or have no deciduous teeth remaining (unless the primary teeth are retained due to ectopic position of the underlying permanent tooth or a missing permanent tooth in this area) or the remaining deciduous teeth have no root structure remaining; permanent dentitions are not required for beneficiaries with cleft palate or craniofacial cases.

D. Score at least 28 points on the HLD Index.

   Only those cases that score 28 points or more on the HLD Index will be considered for comprehensive orthodontic services. This value will be scored by a Medicaid dental consultant based on the diagnostic records provided with the request. This is not to imply that cases scoring less than 28 points do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Arkansas Medicaid program. It is important to note that when scoring the HLD Index, the provider is not diagnosing malocclusion but simply measuring and/or noting the presence or absence of certain key indicators. It is the intention of Arkansas Medicaid to cover only medically necessary orthodontic services.

   Medically necessary care is defined by the American Dental Association as the reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances and devices) as determined and prescribed by qualified, appropriate health care providers in treating any condition, illness, disease, injury or birth developmental malformations. Care is medically necessary for the purpose of: (a) controlling or eliminating infection, pain and disease and (b) restoring facial configuration or function necessary for speech, swallowing or chewing.

226.110 Comprehensive Orthodontic Treatment 8-1-13

Comprehensive orthodontic treatment includes, but is not limited to:

A. Complete diagnostic records and a written treatment plan.

B. Placement of all necessary appliances to properly treat the beneficiary (both removable and fixed appliances).

C. All necessary adjustments.

D. Removal of appliances at the completion of the active phase of treatment.

E. Placement of retainers or necessary retention techniques.

F. Adjustment of the retainers and observation of the beneficiary for a proper period of time (approximately 18 to 24 months).

226.200 Limited Orthodontic Treatment 8-1-13

Limited orthodontic benefits may be available to eligible beneficiaries under 21 years of age that meet one or more of the following criteria:

A. Single or multiple tooth anterior crossbite.

B. Unilateral crossbite with functional shift. Documentation of the shift must be provided, i.e., frontal photo showing midlines off and facial photo showing chin off, etc., and must be essentially all teeth on one side.

C. Bilateral posterior crossbite. There must be two or more teeth on each side to be considered.

D. Impacted teeth. In order to be considered, the impacted teeth must:

1. Have an abnormal eruptive path.
2. Be an anterior tooth.
3. Be covering a portion of the root of an adjacent tooth as assessed on the panoramic film.

226.300 Orthodontic Evaluation 8-1-13

The beneficiary must be a good candidate for comprehensive orthodontic treatment as assessed by the potential provider. The beneficiary must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, etc.) must be completed prior to submission of the Request for Orthodontic Treatment form (Form DMS-32-0). **View or print Form DMS-32-0.**

The beneficiary must also make the necessary arrangements for ancillary services, such as extractions. Extractions are not included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

226.310 Orthodontic (Diagnostic) Records 8-1-13

All orthodontic records must be of diagnostic quality to be considered. Orthodontic records must include a detailed treatment plan; Cephalometric film; Panoramic film (or intraoral complete series); quality diagnostic casts, properly occluded and trimmed (so that the diagnostic casts simulate centric occlusion of the patient when the diagnostic casts are placed on their heels); at least three extraoral photographs (frontal, profile, smile frontal) and five intraoral photographs (right side occluded, left side occluded, anterior occluded, upper and lower arch occlusal views). The diagnostic cast must not be submitted separately, and the provider's and the beneficiary's full names must be clearly inscribed on the upper and lower casts. **All orthodontic records must have been obtained within 6 months of case submission.**

If the diagnostic casts, photographs and/or X-rays are non-diagnostic, they will be rejected and new records must be submitted prior to consideration for treatment.

The orthodontic examination and orthodontic records are only separately reimbursable when a case has been denied. **Records will not be reimbursed if the consultant determines the HLD score is 20 or less when comprehensive treatment has been requested, or 16 or less when limited treatment is requested.**

NOTE: Diagnostic casts will only be returned if the orthodontic case is denied; if approved, they will be destroyed.

226.400 Prior Authorization for Orthodontics 5-1-14

When requesting prior authorization for orthodontic services, the provider *must* complete and submit the Request for Orthodontic Treatment form (Form DMS-32-0), the ADA-J430 claim form for the orthodontic records and a written treatment plan along with the orthodontic records. **View or print form DMS-32-0. View or print form ADA-J430.**

Mail the requested information to the Division of Medical Services Dental Care Unit. For electronic submissions options, contact the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

226.410 Beneficiary Eligibility for Orthodontic Treatment 8-1-13

Upon receipt of an approved Prior Authorization Request form, the dentist must verify the beneficiary's eligibility prior to beginning orthodontic treatment. It is important for the dentist to verify eligibility each time a treatment/service is rendered. Even though a service is prior authorized, the beneficiary MUST be eligible on the date the treatment begins and at the time of each subsequent visit. If eligible, the dentist should proceed to treat the orthodontic condition as soon as possible, in accordance with the prior authorized treatment plan. For instructions on checking eligibility, see Section 223.000 of this manual or contact your Provider Representative.

226.500 Instructions for Reimbursement of Comprehensive and Limited Treatment 8-1-13

For reimbursement of comprehensive or limited orthodontic treatment, a frontal full face photograph, showing the orthodontic appliance in place, must be submitted to the Dental Unit prior to billing. See Section 226.400 for submission address. Allow one to two weeks for release of authorization.

226.600 Orthodontic Transfer Cases 8-1-13

Any beneficiary transferring to Arkansas Medicaid from another state that has started orthodontic treatment may be allowed to complete orthodontic treatment. The amount of reimbursement for the remaining treatment will be based on the Arkansas Medicaid fee schedule and prorated based on the time left in treatment as evaluated by an orthodontic consultant. All requirements for orthodontic treatment as described in Section 226.300 must be met to be considered. Removal of fixed appliances with or without retention may be approved if any of these requirements are not met.

226.610 Premature Termination of Orthodontic Treatment 8-1-13

A release form for premature removal of an orthodontic appliance must be signed by the parent or legal guardian, or by the beneficiary if he/she is 18 years of age or older or an emancipated minor. A copy of the signed release form must be kept in the beneficiary's chart. The following are reasons for premature termination:

A. The beneficiary is uncooperative or is non-compliant.

B. The beneficiary requested the removal of orthodontic appliance(s).

C. The beneficiary has requested the removal due to extenuating circumstances, including, but not limited to:

   1. Relocation.
   2. Incarceration.

3. Mental health complications, with a recommendation from the treating physician.
4. Foster Care placement.
5. Induction in the Armed Forces.

226.700 Retention of Records 8-1-13

Providers are required to retain copies of the beneficiary's history, cephalometric X-rays, panoramic/intraoral series X-rays, photographs and diagnostic casts for a minimum of five (5) years.

227.000 Professional Visits 2-1-22

Professional visits are payable if prior authorized. Because it is not always possible to plan these calls, the provider should submit a claim with a concise explanation of the circumstances. These visits are subject to review by the dental consultant.

When a treatment is necessary and no procedure code is applicable, a written explanation of the treatment and the usual and customary fee charged to a private patient must be submitted to the Medicaid Program. The dental consultant will stipulate an exact fee to be paid if the treatment is authorized. See Sections **262.100** and **262.200** for applicable procedure codes.

228.000 Hospital Services 9-8-14

Effective immediately, dental outpatient hospitalization providers for beneficiaries ages 20 and under no longer requires Prior Authorization (PA). **This change refers to the hospital revenue codes only – 0361, 0360, 0369 and 0509.** Any dental procedures performed in the hospital that would normally require PA (i.e. – surgical extractions, spacers, etc.) will still need to be submitted to the Dental Unit for approval, but the facility does not need prior authorization.

To request prior authorization, the dental treatment plan must be submitted on the ADA claim form with the appropriate X-rays. A copy of the Additional Information form (DMS-32-A) should be attached indicating the reason(s) hospitalization is necessary and the name of the hospital. **View or print form DMS-32-A**.

In unusual cases, for beneficiaries under age 21, when it is impossible to determine the treatment plan before the patient is anesthetized, indicate the information on the DMS-32-A. Beneficiaries age 21 and over are not covered for general anesthesia, nitrous oxide and non-intravenous conscious sedation.

The provider must complete the first portion of the ADA claim form (the ID of the patient and doctor) and submit both forms together. After the treatment is performed, any procedure(s) requiring prior authorization must be submitted to the dental consultant for authorization.

228.100 Inpatient Hospital Services 8-1-13

Hospitalization for dental treatment may be approved when the patient's age, medical or mental problems and/or the extensiveness of treatment necessitates hospitalization. Consideration is given in cases of traumatic accidents and extenuating circumstances.

Because of the cost of a hospital stay, providers are encouraged to use outpatient hospital care whenever feasible. The length of hospitalization should be kept to a minimum.

Request for hospitalization should be made only when other methods such as premedication, delay of treatment, limited in office treatment, sedation, etc., have been evaluated.

228.200 Outpatient Hospital Services 8-1-13

When a primary procedure to be performed in outpatient surgery is medical in nature, Arkansas Medicaid will not cover a dental procedure that is incidental to the primary procedure (e.g., the removal of a wisdom tooth when a tonsillectomy is being performed). When the primary procedure is medical, and it is cancelled, the provider may request a prior authorization for the dental procedure to be performed as outpatient surgery.

Information that should be included in the request for prior authorization for outpatient surgery includes the following.

A. An explanation for the reason the dental procedure cannot be performed in the provider's office.

B. An explanation for the reason a dental procedure cannot be postponed. (e.g., a procedure that cannot be postponed until a child matures and becomes receptive to a dental office environment and treatment.)

C. The provider should also state whether sedation or general anesthesia will be used during the procedure for beneficiaries under age 21. **Note: General anesthesia, nitrous oxide and non-intravenous conscious sedation are not covered for beneficiaries age 21 and over.**

D. A copy of the dental treatment plan must be included with the prior authorization request.

For outpatient hospitalization, all procedures involved must be indicated on the treatment plan.

229.000 Adult Services 4-30-10

Effective for dates of service on and after July 1, 2009, Arkansas Medicaid covers dental treatment for beneficiaries who are 21 years of age and older.

Treatment for beneficiaries age 21 and over includes:

A. Dental screenings

B. Radiographs – periapical (first and additional film) and bitewings

C. Prophylaxis and fluoride treatment

D. Amalgam restorations

E. Composite resin restorations

F. Diagnostic Casts

G. Prefabricated stainless steel permanent crowns and re-cementing crowns

H. Periodontal scaling, root planning and other maintenance procedures

I. Complete and partial dentures and certain repairs for dentures

J. Simple extractions

K. Surgical extractions

L. Treatment of dental pain

M. Biopsies of oral tissue

N. Incision and drainage of abscesses

O. Tobacco counseling

Treatment does not include:

A. Dental sealants

B. Space maintainers/orthodontic treatment

C. Resin or porcelain-ceramic substrate crowns

D. Pulpotomies

E. Root canal therapy

F. Tooth reimplantation/stabilization

G. Consultations

H. General anesthesia, nitrous oxide and non-intravenous conscious sedation

In general, Arkansas Medicaid does not cover dental treatment not specified above for adults who are 21 years of age and older. An exception to this general rule is dental treatment that is medically necessary.

Medically necessary dental treatment is defined as dental care that will stabilize a life-threatening medical condition or dental care for a condition that, if not treated, could result in death.

The above exception is limited to services related to extractions only.

All medically necessary dental care must be pre-approved by medical and dental consultants at the Division of Medical Services. All adult dental care services claims may be submitted electronically or on paper.

The review process must include:

A. The identification of a life-threatening medical problem affected by oral health. Some examples of such conditions are:

    1. HIV/AIDS patients with infections the immune system is unable to fight

    2. Transplant patients with infected teeth or gums

    3. Cancer radiation treatments to the head/neck/jaw

B. Letters of medical necessity must be submitted by the primary care physician and the dentist who will perform the dental services detailing the medical condition and the effects the oral health problems have on the overall health of the beneficiary. Any supporting information, including x-rays, to further substantiate medically necessary treatment must also be submitted.

C. Upon receipt, the Division of Medical Services medical and dental consultants will evaluate the information submitted and authorize the dental treatment, if any, that Medicaid will reimburse. After the review process is completed, the panel will return to the dental provider any x-rays, along with an approval or denial, to perform the requested services.

D. The office of the dental provider will notify the beneficiary regarding the decision of the Division of Medical Services consultants, and, if appropriate, arrange to begin dental care.

The medical and dental consultants will only approve dental treatment for adults who strictly meet the medical necessity criteria.

Reconstructive surgery for cosmetic purposes and dental implants are not covered services.

230.000 PRIOR AUTHORIZATION

231.000 Procedure for Obtaining Prior Authorization 4-15-09

Certain dental and surgical procedures require prior authorization (PA). The prior authorization may be required because of federal requirements, the elective nature of the service or other reasons.

All requests for prior authorization should be submitted to the **Dental Care Unit of the Arkansas Division of Medical Services** by the attending dentist/orthodontist on the ADA claim form.

Procedures requiring prior authorization must be approved by the Dental Care Unit before the procedure is performed.

Payment is subject to verification of the beneficiary's eligibility at the time of the service. Prior authorization does NOT guarantee payment. It is the provider's responsibility to verify and print the beneficiary's eligibility for benefits on the date of service PRIOR to rendering authorized services.

232.000 Duration of Authorization 4-15-09

Prior authorizations are valid for one (1) year provided the beneficiary remains eligible for services. Because Medicaid eligibility may vary from month to month, the Medicaid Program cannot predict whether a beneficiary for whom authorization has been given will remain eligible.

The Medicaid Program provides reimbursement for services for eligible beneficiaries only. Prior authorization does not guarantee payment. **The beneficiary must be eligible on the date of service and the claim must meet all applicable requirements.** If the beneficiary becomes ineligible for Medicaid benefits, the authorization is void.

The Medicaid beneficiary is responsible for informing the dental care provider on the initial visit that he or she is eligible for Medicaid and must present his or her Medicaid card to the provider. However, the Medicaid card, alone, is insufficient for verification of eligibility. The provider must also review the Medicaid system to verify current eligibility.

The dental care provider has the option whether or not to provide dental care to the Medicaid beneficiary. If the dental care provider chooses to treat the Medicaid beneficiary, the provider is not obligated to bill Medicaid; however, the provider should inform the Medicaid beneficiary if he or she is willing to bill Medicaid before services are provided. Billing Medicaid for covered services provided to an eligible beneficiary obligates the dental care provider to accept the Medicaid determined payment amount as payment-in-full for those services. See Section I of this manual for complete information of provider and beneficiary responsibilities.

If the beneficiary's Medicaid identification number changes, the authorization must be updated with the new identification number. Providers must return the treatment plan to Medicaid with a notation of the new number. The provider may proceed with treatment while the update is being processed.

If the authorized treatment cannot be completed in one (1) year and the beneficiary is still eligible for Medicaid benefits, the provider may return the treatment plan and request an update. The provider may request an update and proceed with treatment while the update is being processed.

233.000 Standard Prior Authorization Procedures 4-15-09

After examining a beneficiary and verifying his or her eligibility under the Medicaid Program, the provider should complete the ADA claim form as described in Section 262.300 and mail all

copies of the form with X-rays, if required, to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**.

If the treatment plan outlined on the ADA claim form is not self-explanatory, the provider must complete and attach the form DMS-32-A to the treatment plan. The X-rays should be properly identified with both the name of the dentist and the beneficiary and must be stapled to the ADA claim form. All X-rays must be dated and labeled with the name of the dentist and the beneficiary. **View or print DMS-32-A form and instructions for completion.**

233.100 Review of Treatment Plan 6-1-06

The treatment plan will be reviewed by a dental consultant with the Division of Medical Services' Dental Care Unit.

A. If the treatment plan is denied, the ADA claim form will be returned to the provider with an explanation of the denial on form DMS-2635 (Dental Disposition Form). **View or print form DMS-2635**.

B. If additional information is needed, the treatment plan will be returned with the disposition form detailing the reason for return. The prior authorization request may be resubmitted with the required information.

C. If the request is approved in full, each procedure code will be checked in blue. The original and one copy of the ADA claim form will be returned to the provider with the assigned prior authorization number. Service may then be provided.

D. If the request is only partially approved, those procedures of the treatment plan denied will be marked "NO" on the ADA claim form and those procedures approved will be marked in red. The prior authorization number will apply only to those procedures of the treatment plan shown as being approved.

E. The prior authorization number will be indicated in Section 9 of the ADA claim form if the treatment plan is completely or partially approved.

234.000 Emergency Procedures 10-13-03

For services that require prior authorization, the services must be approved by the Division of Medical Services Dental Care Unit prior to the provision of the services in order to be reimbursed by Medicaid. However, in certain medical emergencies, services may be reimbursed when authorization is made after the provision of services. In such emergency cases, the treatment plan and services must still be approved by the Medicaid Program's dental consultants PRIOR TO PAYMENT.

The provider may contact the Dental Care Unit for technical advice on Medicaid payment policies in such medical emergencies**.** **View or print the Division of Medical Services Dental Unit contact information**.

235.000 Orthodontia Prior Authorization 10-13-03

Section 226.000 contains information regarding the Medicaid coverage of orthodontia services.

The ADA claim form is used to request prior authorization for orthodontic services. The ADA claim form must be accompanied by form DMS-32-0, titled, Request for Orthodontic Treatment. **View or print the ADA claim form**. **View or print DMS-32-O form and instructions.**

Models, cephalometric films and photo should be submitted with the completed ADA claim form to the Division of Medical Services Dental Care Unit.

View or print the Division of Medical Services Dental Care Unit contact information.

The treatment should not begin until approval has been received.

If the treatment plan is approved, a prior authorization control number will be issued and must be used on all claims submitted for payment. Payment may be made for the full amount of the orthodontic treatment (or less if indicated). Records are included in the overall fee for orthodontia.

If treatment is denied, the reason for denial will be indicated. The provider may then submit a claim for cephalometric film, study models, full-mouth X-rays and photo to the Dental Care Unit for approval and payment.

236.000 Prescription Prior Authorization 3-14-15

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. Certain prescription drugs may require prior authorization.

The dental provider must request prior authorization before prescribing a prescription drug to an eligible Medicaid beneficiary.

Dental providers must refer to the website at **https://arkansas.magellanrx.com/provider/documents/** for information relative to:

A. Prescription drugs requiring prior authorization

B. Drugs subject to specific prescribing requirements

C. Criteria for drugs requiring prior authorization

240.000 REIMBURSEMENT

241.000 Method of Reimbursement 7-1-06

Arkansas Medicaid reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

241.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

242.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the

action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the questions and will submit a recommendation to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-20

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

262.000 ADA Billing Procedures

262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21 2-1-22

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

NOTE: Only physicians who have completed the training on dental caries and have an approved fluoride varnish certification on file with Provider Enrollment can bill for the fluoride varnish treatment. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Providers must check the Supplemental Eligibility Screen to verify that topical fluoride treatment or fluoride varnish was not applied by another Medicaid dental provider.

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

* Revenue code

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

** Prior authorization is required for panoramic X-rays performed on children under six years of age (See Section 216.100).

Child Health Services (EPSDT) Dental Screening (See Section 215.000)
Radiographs (See Sections 216.000 – 216.300)
Tests and Laboratory
Preventive
Dental Prophylaxis (See Section 217.100)
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)
Dental Sealants (See Section 217.200)
Space Maintainers (See Section 218.000)
Restorations (See Sections 219.000 – 219.200)
Amalgam Restorations (including polishing) (See Section 219.100)
Composite Resin Restorations (See Section 219.200)
Crowns – Single Restoration Only (See Section 220.000)
Endodontia (See Section 221.000)
Pulpotomy
Endodontic (Root Canal) therapy (including treatment plan, clinical procedures and follow-up care)
Periapical Services
Periodontal Procedures (See Section 222.000)
Surgical Services (including usual postoperative services)
Complete dentures (Removable Prosthetics Services) (See Section 223.000)
Partial Dentures (Removable Prosthetic Services) (See Section 223.000)
Repairs to Partial Denture (See Section 223.000)
Fixed Prosthodontic Services (See Section 224.000)
Oral Surgery (See Section 225.000)
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)
Other Surgical Procedures
Osteoplasty for Prognathism, Micrognathism or Apertognathism
Frenulectomy
Orthodontics (See Section 226.000)
Minor Treatment of Control Harmful Habits
Comprehensive Orthodontic Treatment – Permanent Dentition
Other Orthodontic Devices
Anesthesia
Consultations (See Section 214.000)
Smoking Cessation

Unclassified Treatment

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older 2-1-22

The following list shows the procedure code, procedure code description, whether or not prior authorization is required, whether an X-ray should be submitted with a treatment plan and if there is a benefit limit on a procedure.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates **"Yes, $500.00",** then that item, when used in combination with other items listed, cannot exceed the $500.00 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If **"No"** is shown, the item is not benefit limited.

NOTE: The use of the symbol, ⁂, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Dental Screening (See Section 215.000)
Radiographs (See Sections 216.000 – 216.300)
Tests and Laboratory
Dental Prophylaxis (See Section 217.100)
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)
Restorations (See Sections 219.000 – 219.200)
Amalgam Restorations (including polishing) (See Section 219.100)
Composite Resin Restorations (See Section 219.200)
Crowns – Single Restoration Only (See Section 220.000)
Surgical Services (including usual postoperative services)
Repairs to Complete and Partial Dentures (See Section 223.000)
Fixed Prosthodontic Services (See Section 224.000)
Oral Surgery (See Section 225.000)
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)
Other Surgical Procedures
Osteoplasty for Prognathism, Micrognathism or Apertognathism
Unclassified Treatment
Smoking Cessation

262.300 ADA National Place of Service (POS) Codes 7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office/Clinic	11
Other location	99

262.400 Billing Instructions – ADA Claim Form - Paper Claims Only 2-1-22

Dental providers must complete the ADA claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the “Request for Payment for Services Provided” portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information.**

Completed claim forms should be forwarded to the Claims Department. **View or print the Claims Department contact information.**

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the patient Medicaid ID number.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.

Field Number and Name	Instructions for Completion
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in **Section 262.100** for beneficiaries under age 21 or **Section 262.200** for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.

Field Number and Name	Instructions for Completion
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility The full list is available online at http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.

Field Number and Name	Instructions for Completion
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. **View or print form ADA-J430**.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.

Field Number and Name	Instructions for Completion
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in “31” for Dentists or “80” for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with “08” for an individual Dentist number or “79” for an individual Oral Surgeon number.

262.500 Special Billing Procedures for ADA Claim Form 2-1-22

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials
3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made for beneficiaries under age 21, the dentist must use procedure code rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code must be used for the first film and procedure code for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist’s provider number and the beneficiary identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals for beneficiaries under age 21. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

E. Prophylaxis and fluoride must be indicated on the same line of the form using code. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code, intraoral single film. When a complete series is made for beneficiaries under age 21, providers must use code rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Use procedure code for prophylaxis-adult, ages 10 through 99, and procedure code for prophylaxis-child, ages 0 through 9.

263.000 CMS-1500 Billing Procedures 4-1-05

Oral surgeons billing CPT procedure codes must use the CMS-1500 form.

263.100 CPT Procedure Codes 2-1-22

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

A. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter “E” in Field 24H.

B. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor’s office, patient’s home, nursing home and skilled nursing facility.

C. Radiology procedures are payable only in the dentist’s office. The place of service (POS) codes may be found in Section 262.300 of this manual. **These services require a PCP referral**.

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each service must be billed on a separate form. See Section 263.300 for complete billing instructions.

A. When billing for extractions, a listing of teeth extracted by date, tooth number and ADA code number must be attached.

B. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

263.110 CPT Procedure Codes that Require Prior Authorization Before Performing the Procedure 2-1-22

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

263.120 Reserved 10-1-09

263.200 National Place of Service (POS) Codes 7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office/Clinic	11

Place of Service	POS Codes
Other location	99
Ambulatory Surgical Center	24

263.300 Billing Instructions – CMS-1500 – Paper Claims Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

263.310 Completion of CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.

Field Name and Number			Instructions for Completion
		CITY	
		STATE	
		ZIP CODE	
		TELEPHONE (Include Area Code)	
8.		RESERVED	Reserved for NUCC use.
9.		OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	RESERVED	Reserved for NUCC use.
		SEX	Not required.
	c.	RESERVED	Reserved for NUCC use.
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.		IS PATIENT'S CONDITION RELATED TO:	
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.		INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a.	INSURED'S DATE OF BIRTH	Not required.
		SEX	Not required.
	b.	OTHER CLAIM ID NUMBER	Not required.
	c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.300 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from **Section 262.100** or **Section 262.200**.
MODIFIER	Modifier(s) if applicable.

Field Name and Number			Instructions for Completion
	E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
	F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
	G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
	H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
	I.	ID QUAL	Not required.
	J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
		NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER		Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.		Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?		Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE		Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID		Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid ARKids First-B co-payments.
30.	RESERVED		Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS		The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

263.400 Special Billing Procedure for the CMS-1500 Claim Form 2-1-22

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary. **View a CMS-1500 sample form.** These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: Procedure code (Hospital Discharge Day Management) is payable for medical services. Procedure code may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible beneficiaries of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible beneficiaries under the age of 21 years participating in the Child Health Services (EPSDT) Program.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.410 Multiple Quadrants Billing Instructions 2-1-22

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a patient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.420 Anesthesia Services 2-1-22

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the Current Procedural Terminology (CPT-4) code book.

B. Providers must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, any applicable modifier(s) are also required.

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G.

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires medical care services. When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, and must bill "1" unit of service.

Procedure code may be billed by oral surgeons for anesthesia for inpatient or outpatient dental surgery using place of service code 24, 21, 22, or 11, as appropriate. The code does not require prior approval for anesthesia claims.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.421 Anesthesia Procedure Codes 2-1-22

Oral surgeons must use the following anesthesia procedure codes when billing on paper.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.422 Reserved 7-1-07

263.423 Guidelines for Anesthesia Values 10-13-03

All anesthesia values are determined by adding a Basic Value, which is related to the complexity of the service, plus Modifiers (P1 through P5), qualifying circumstances and Time Units.

A Basic Value includes the value of all anesthetic services except the time actually spent administering the anesthesia, modifiers and any qualifying circumstance. The Basic Value includes usual pre-operative and post-operative visits and the administration of fluids and/or blood incident to the anesthesia. The Basic Value for anesthesia when multiple surgical procedures are performed is the Basic Value for the procedure with the highest unit value.

Enter only the time points in the units of service Field 24G on the claim. The system will automatically assign the correct number of base points and modifiers.

263.424 Time Units 10-13-03

Time units will be automatically added to the Basic Value, the Anesthesia Modifier and qualifying circumstances for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision. Enter the time units in Field 24G.